

A. Applicant Information

Employer / Group Name _____ New Application Revision to Present Plan *(Please check one)*

Mailing Address _____ City _____ Province _____ Postal Code _____

Business Location _____ City _____ Province _____ Postal Code _____

Telephone Number (_____) _____ Fax Number (_____) _____

Nature of Employer's Business _____ Date Established DD / MM / YYYY

Legal Status: Corporation Partnership Proprietorship Association Other *(please indicate)* _____

Full names of Branch Affiliates or Subsidiaries *(list all that are to be included all under one monthly invoice)*

Affiliated	Subsidiary	Name and Address	# of Employees
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		

Group Administrator(s)

Primary Name _____ Title _____
 Phone (_____) _____ Fax (_____) _____ Email Address _____

Secondary Name _____ Title _____
 Phone (_____) _____ Fax (_____) _____ Email Address _____

B. Selection of Coverage, Monthly Premium Calculation

Waiting period for new employees hired after effective date of insurance: 3 months Other *(please specify)* _____

<input type="checkbox"/> Permanent Full-time	# of Employees	<input type="checkbox"/> Permanent Part-time	# of Employees	<input type="checkbox"/> Contract or Seasonal	# of Employees	<input type="checkbox"/> Other	Type	# of Employees
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Health & Dental Coverage

Custom Health	# of Single _____ X Rate _____	\$ _____
	# of Family _____ X Rate _____	\$ _____
Custom Dental	# of Single _____ X Rate _____	\$ _____
	# of Family _____ X Rate _____	\$ _____

ASO Yes No Administration Fee _____

Please attach a schedule of benefits indicating chosen extended health and dental plans.

Life & Disability Coverage

Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Cost per \$1,000:	\$ _____
AD & D	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Cost per \$1,000:	\$ _____
Dependant Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Cost per Family:	\$ _____
Weekly Indemnity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Cost per \$10:	\$ _____
Long Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Cost per \$100	\$ _____
Enhanced Critical Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Cost incorporated with Long-Term Disability</i>	
Optional Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Cost per \$1,000:	\$ _____

Subtotal: Health & Dental \$ _____

Subtotal: Life & Disability \$ _____

Total Monthly Premium: (Health & Dental \$ _____ + Life & Disability \$ _____) + PST *(Ontario only)* \$ _____ = \$ _____
 Total Monthly Premium

For Office Use Only: Date Received: DD / MM / YYYY BDC: _____ Agent #1: _____ Agent #2: _____ Split: A1 % / A2 %

C. Payment Options

Choose one of the following payment options:

Pre-authorized Payment (complete a Pre-Authorized Debit Agreement)

Cheque

Requested Effective Date of this Plan: 1st day of _____ MONTH _____, _____ YYYY.

D. Additional Information

Are any employees or dependants currently hospital confined or otherwise disabled or handicapped? Yes No

Is this plan to be in addition to any other group life and/or health plan presently in force? Yes No

Is this plan intended to replace any existing coverage? Yes No (If YES, please complete the following section)

Benefit	Name of Current Carrier	Effective Date of Present Coverage
Extended Health Care		DD / MM / YYYY
Dental Care		DD / MM / YYYY
Life		DD / MM / YYYY
AD & D		DD / MM / YYYY
Optional Life		DD / MM / YYYY
Optional AD & D		DD / MM / YYYY
Dependant Life		DD / MM / YYYY
Weekly Indemnity		DD / MM / YYYY
Long Term Disability		DD / MM / YYYY

Premium Contributions:

	Employer %	Employee %		Employer %	Employee %
Extended Health Care	_____	_____	Dependant Life	_____	_____
Dental Care	_____	_____	Weekly Indemnity	_____	_____
Life/AD & D	_____	_____	Long Term Disability	_____	_____

E. Declaration

The applicant hereby declares that, to the best of the applicant's knowledge, the statements and answers contained herein are full, complete and true as of the date hereof and expressly agrees that (1) such statements and answers shall constitute the application for the contract and form part of the contract, and (2) the coverage shall become effective in accordance with and subject to the policy to be issued to the applicant but in no case shall it become effective until this application has been approved by GMS. Group Medical Services will not be liable to the applicant or to any of the applicant's employees until the application is approved. The applicant understands that the Life, AD&D, Dependent Life, Weekly Indemnity and Long Term Disability are provided by The Wawanesa Life Insurance Company ("Wawanesa Life") and that GMS acts only as the administrative agent for Wawanesa Life Insurance Company in placing and administering such coverage. Wawanesa Life Insurance Company and not GMS has the authority and responsibility for assessing and approving your application for such coverage and any claims made thereunder. As such, any policy providing such coverage, if approved by Wawanesa Life, will be a contract with Wawanesa Life and the information you have supplied in this application will be provided to and relied on by Wawanesa Life and included as part of that contract. The undersigned understands that he/she has the authority to sign on behalf of the applicant and understands that, whether before or after the date of application, any misrepresentation, incorrect or concealed information or failure to fully complete all sections of the application may void the coverage.

Do not terminate any existing coverage until notice has been given in writing that the coverage being applied for is approved by Group Medical Services.

Dated at _____ CITY OR TOWN this _____ DD day of _____ MONTH _____, _____ YYYY.

by _____
Applicant Signature

Please Print Name and Title